

## **HOUSE BILL No. 1086**

DIGEST OF HB 1086 (Updated February 11, 2009 12:02 pm - DI 97)

Citations Affected: IC 27-8; IC 27-13.

**Synopsis:** Assignment of benefits. Specifies requirements with respect to an assignment of benefits under a policy of accident and sickness insurance or a health maintenance organization contract.

Effective: July 1, 2009.

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January 7, 2009, read first time and referred to Committee on Insurance. February 12, 2009, amended, reported — Do Pass.

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First Regular Session 116th General Assembly (2009)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or *this style type* reconciles conflicts between statutes enacted by the 2008 Regular Session of the General Assembly.

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## **HOUSE BILL No. 1086**

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A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

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Be it enacted by the General Assembly of the State of Indiana:

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1	SECTION 1. IC 27-8-5.9 IS ADDED TO THE INDIANA CODE
2	AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
3	JULY 1, 2009]:

Chapter 5.9. Assignment of Benefits

- Sec. 1. As used in this chapter, "assignment of benefits" means a written instrument that:
  - (1) is executed by a covered individual or the authorized representative of a covered individual; and
  - (2) assigns to a provider the covered individual's right to receive reimbursement for health care services provided to the covered individual.
- Sec. 2. As used in this chapter, "covered individual" means an individual entitled to benefits under a policy.
- Sec. 3. As used in this chapter, "health care services" has the meaning set forth in IC 27-8-11-1. The term includes ambulance services.
- 17 Sec. 4. As used in this chapter, "policy" means a policy of

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HB 1086—LS 6065/DI 97+

1	accident and sickness insurance (as defined in IC 27-8-5-1).	
2	Sec. 5. As used in this chapter, "provider" has the meaning set	
3	forth in IC 27-8-11-1. The term includes an ambulance service	
4	provider.	
5	Sec. 6. (a) Except as provided in subsection (b), if:	
6	(1) a policy provides coverage for a health care service;	
7	(2) the health care service is rendered by a provider that has	
8	not entered into an agreement with the insurer under	
9	IC 27-8-11-3; and	
10	(3) the provider:	
11	(A) has an assignment of benefits from the covered	
12	individual to whom the health care service is rendered;	
13	and	
14	(B) provides written or electronic notification to the	
15	insurer that the provider:	
16	(i) has rendered the health care service to the covered	
17	individual; and	
18	(ii) has the assignment of benefits;	
19	the insurer shall make a benefit payment directly to the provider	
20	for the health care service and send written notice of the payment	
21	to the covered individual or the authorized representative of the	
22	covered individual.	
23	(b) An insurer is not required to make a benefit payment	
24	directly to a provider described in subsection (a) if the provider has	_
25	been convicted of fraud.	
26	(c) This section does not require:	
27	(1) coverage for benefits not covered under the terms of a	
28	policy; or	
29	(2) payment to a provider that is not eligible for a benefit	
30	payment under the terms of a policy.	
31	Sec. 7. If:	
32	(1) a provider is entitled to a direct benefit payment under	
33	section 6 of this chapter;	
34	(2) the insurer makes the benefit payment directly to the	
35	covered individual or the authorized representative of the	
36	covered individual rather than to the provider; and	
37	(3) the provider notifies the insurer that the provider has not	
38	received the benefit payment;	
39	the insurer, not more than thirty (30) days after receiving the	
40	notice from the provider, shall make the benefit payment directly	
41 42	to the provider.	
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1	(1) a provider is entitled to a direct benefit payment under
2	section 6 of this chapter; and
3	(2) there is a good faith dispute regarding the:
4	(A) legitimacy of the claim relating to the health care
5	service rendered;
6	(B) appropriate amount of reimbursement for the claim;
7	or
8	(C) authorization for the assignment of benefits;
9	the insurer, not more than fourteen (14) business days after the
10	insurer receives the claim and all documentation reasonably
11	necessary to determine claim payment, shall provide notice of the
12	dispute to the provider or the provider's authorized representative.
13	Sec. 9. (a) Except as provided in subsection (c), a provider that
14	has not entered into an agreement with an insurer under
15	IC 27-8-11-3 or the provider's agent shall disclose to a covered
16	individual the following applicable information:
17	(1) That the provider has not entered into an agreement with
18	the insurer to provide health care services to the covered
19	individual.
20	(2) That the covered individual may be billed for health care
21	services for which payment is not made by the insurer.
22	(b) A disclosure required by subsection (a) must be:
23	(1) made in writing; and
24	(2) if included in a document containing consent for
25	treatment, displayed conspicuously.
26	(c) A disclosure is not required under subsection (a) if any of the
27	following apply:
28	(1) The patient is unconscious, incoherent, or incompetent.
29	(2) The patient:
30	(A) arrives at a hospital required to provide emergency
31	medical screening or care under 42 U.S.C. 1395dd; and
32	(B) seeks emergency medical screening or care.
33	(3) The provider does not know and could not reasonably
34	know that the patient is covered under a policy issued by an
35	insurer with which the provider has not entered into an
36	agreement for the delivery of health care services.
37	(4) The provider has been requested to render health care
38	services to the covered individual after the covered individual
39	has been admitted for inpatient or outpatient services and the
40	provider's services were not part of the original treatment
41	plan.
42	Sec. 10. (a) An insurer that does not comply with this chapter



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1	shall pay interest for each day of noncompliance at the same	
2	interest rate as provided in IC 12-15-21-3(7)(A).	
3	(b) IC 27-8-5.7 applies to payment of a claim submitted to an insurer by a provider in compliance with this chapter.	
5	Sec. 11. A provider, by accepting an assignment of benefits	
6	under this chapter, does not agree to accept an insurer's fee	
7	schedule or specific payment rate as payment in full, partial	
8	payment, or appropriate payment.	
9	Sec. 12. A policy provision or contract provision that violates	
10	this chapter is void.	
11	SECTION 2. IC 27-13-36.3 IS ADDED TO THE INDIANA CODE	
12	AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE	
13	JULY 1, 2009]:	
14	Chapter 36.3. Assignment of Benefits	
15	Sec. 1. As used in this chapter, "assignment of benefits" means	
16	a written instrument that:	7
17	(1) is executed by an enrollee or the authorized representative	
18	of an enrollee; and	
19	(2) assigns to a nonparticipating provider the enrollee's right	
20	to receive reimbursement for health care services provided to	
21	the enrollee.	_
22	Sec. 2. As used in this chapter, "health care services" includes	
23	ambulance services.	
24	Sec. 3. As used in this chapter, "health maintenance	
25	organization" includes a limited service health maintenance	
26	organization.	
27	Sec. 4. As used in this chapter, "nonparticipating provider"	
28	means a provider that has not entered into an agreement described	7
29	in IC 27-13-1-24.	
30	Sec. 5. As used in this chapter, "provider" includes an	
31	ambulance service provider.	
32	Sec. 6. (a) Except as provided in subsection (b), if:	
33	(1) an individual contract or a group contract provides	
34	coverage for a health care service;	
35	(2) the health care service is rendered by a nonparticipating	
36	provider; and	
37	(3) the nonparticipating provider:	
38	(A) has an assignment of benefits from the enrollee to	
39	whom the health care service is rendered; and	
40	(B) provides written or electronic notification to the health	
41	maintenance organization that the nonparticipating	
42	provider:	



1	(i) has rendered the health care service to the enrollee;	
2	and	
3	(ii) has the assignment of benefits;	
4	the health maintenance organization shall make a benefit payment	
5	directly to the nonparticipating provider for the health care service	
6	and send written notice of the payment to the enrollee or the	
7	authorized representative of the enrollee.	
8	(b) A health maintenance organization is not required to make	
9	a benefit payment directly to a nonparticipating provider	
10	described in subsection (a) if the nonparticipating provider has	
11	been convicted of fraud.	
12	(c) This section does not require:	•
13	(1) coverage for benefits not covered under the terms of an	
14	individual contract or a group contract; or	
15	(2) payment to a nonparticipating provider that is not eligible	
16	for a benefit payment under the terms of an individual	4
17	contract or a group contract.	
18	Sec. 7. If:	
19	(1) a nonparticipating provider is entitled to a direct benefit	
20	payment under section 6 of this chapter;	
21	(2) the health maintenance organization makes the benefit	
22	payment directly to the enrollee or the authorized	
23	representative of the enrollee rather than to the	
24	nonparticipating provider; and	
25	(3) the nonparticipating provider notifies the health	
26	maintenance organization that the nonparticipating provider	
27	has not received the benefit payment;	
28	the health maintenance organization, not more than thirty (30)	
29	days after receiving the notice from the nonparticipating provider,	
30	shall make the benefit payment directly to the nonparticipating	
31	provider.	
32	Sec. 8. If:	
33	(1) a nonparticipating provider is entitled to a direct benefit	
34	payment under section 6 of this chapter; and	
35	(2) there is a good faith dispute regarding the:	
36	(A) legitimacy of the claim relating to the health care	
37	service rendered;	
38	(B) appropriate amount of reimbursement for the claim;	
39	or	
40	(C) authorization for the assignment of benefits;	
41	the health maintenance organization, not more than fourteen (14)	
42	business days after the health maintenance organization receives	



1	the claim and all documentation reasonably necessary to determine
2	claim payment, shall provide notice of the dispute to the
3	nonparticipating provider or the nonparticipating provider's
4	authorized representative.
5	Sec. 9. (a) Except as provided in subsection (c), a
6	nonparticipating provider or the nonparticipating provider's agent
7	shall disclose to an enrollee the following applicable information:
8	(1) That the provider is not a participating provider.
9	(2) That the enrollee may, subject to IC 27-13-36-5 and
10	IC 27-13-36-9, be billed for health care services for which
11	payment is not made by the health maintenance organization.
12	(b) A disclosure required by subsection (a) must be:
13	(1) made in writing; and
14	(2) if included in a document containing consent for
15	treatment, displayed conspicuously.
16	(c) A disclosure is not required under subsection (a) if any of the
17	following apply:
18	(1) The patient is unconscious, incoherent, or incompetent.
19	(2) The patient:
20	(A) arrives at a hospital required to provide emergency
21	medical screening or care under 42 U.S.C. 1395dd; and
22	(B) seeks emergency medical screening or care.
23	(3) The provider does not know and could not reasonably
24	know that the patient is covered under an individual contract
25	or a group contract entered into by a health maintenance
26	organization for which the provider is not a participating
27	provider.
28	(4) The provider has been requested to render health care
29	services to the enrollee after the enrollee has been admitted
30	for inpatient or outpatient services and the provider's services
31	were not part of the original treatment plan.
32	Sec. 10. (a) A health maintenance organization that does not
33	comply with this chapter shall pay interest for each day of
34	noncompliance at the same interest rate as provided in
35	IC 12-15-21-3(7)(A).
36	(b) IC 27-13-36.2 applies to payment of a claim submitted to a
37	health maintenance organization by a nonparticipating provider in
38	compliance with this chapter.
39	Sec. 11. A nonparticipating provider, by accepting an
40	assignment of benefits under this chapter, does not agree to accept
41	a health maintenance organization's fee schedule or specific

payment rate as payment in full, partial payment, or appropriate



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- 1 payment.
- 2 Sec. 12. A contract provision that violates this chapter is void.

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## COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1086, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB 1086 as introduced.)

FRY, Chair

Committee Vote: yeas 6, nays 5.







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